

FEDERAL PHYSICIANS COMPARABILITY LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE,
POST OFFICE, AND GENERAL SERVICES

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

S. 369

FOR THE RELIEF OF CERTAIN GOVERNMENT PHYSICIANS WHO WERE
PAID BASIC PAY, PERFORMANCE AWARDS, AND PHYSICIANS COMPA-
RABILITY ALLOWANCES IN AGGREGATE AMOUNTS EXCEEDING THE
LIMITATION SET FORTH IN SECTION 5383(b) OF TITLE 5, UNITED
STATES CODE

AND

S. 1009

TO AUTHORIZE FEDERAL PHYSICIANS COMPARABILITY ALLOWANCES

MAY 25, 1983

Printed for the use of the Committee on Governmental Affairs



U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1983

21-905 O

S401-57

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FEDERAL PHYSICIANS COMPARABILITY LEGISLATION

WEDNESDAY, MAY 25, 1983

U.S. SENATE,
SUBCOMMITTEE ON CIVIL SERVICE,
POST OFFICE, AND GENERAL SERVICES,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The subcommittee met at 10 a.m., in room 116, Dirksen Senate Office Building, Hon. Ted Stevens (chairman of the subcommittee) presiding.

Present: Senators Stevens and Mathias.

Staff present: Wayne A. Schley, staff director; Jamie Cowen, special counsel; Edwin S. Jayne, minority staff director; Pat Halcomb, chief clerk; and Eileen Mayer, counsel to Senator Mathias.

OPENING STATEMENT OF SENATOR STEVENS

Senator STEVENS. Good morning. Today, we are holding a hearing on S. 1009, a bill to reauthorize the physicians comparability allowance program, and on S. 369, a bill to grant relief to certain Federal physicians from a requirement to remunerate the Government due to the receipt of allowances in excess of the statutory cap.

The purpose of the physicians comparability allowance program is to aid recruitment and retention of highly qualified Government physicians for a specified period of service in a particular agency. In return for this benefit to the Government, the physician receives an allowance for the duration of the agreement in an amount determined by the agency head and specified in the agreement.

Under section 5948(d) of title 5 of the United States Code, the physicians comparability allowance program provides that:

No agreement shall be entered into under this section later than September 30, 1983, nor shall any agreement cover a period of service extending beyond September 30, 1985.

S. 1009 permanently reauthorizes the program. Information from prior years has revealed that this program has been very successful. Many agencies have attested to the fact that without it, they would experience difficulty in recruiting and retaining medical doctors. We look forward to hearing from our witnesses today to recommend if any improvements are warranted in the program and whether it should be permanently reauthorized.

Turning to S. 369, it deals, in a sense, with a problem resulting from implementation of the allowance program. Under the current

law, these physicians are not permitted to receive an allowance that, when coupled with their pay, would exceed the Executive Level I pay. Apparently, a few physicians were unknowingly paid the excessive amount, and current law would require them to repay the overage. S. 369 will forgive those individuals from their current obligation to repay that amount.

Our first witness this morning is Thomas McFee, Assistant Secretary for Personnel Administration, Department of Health and Human Services.

TESTIMONY OF THOMAS S. McFEE, ASSISTANT SECRETARY FOR PERSONNEL ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. McFEE. I would like to thank you, Mr. Chairman, for inviting me to testify before the subcommittee on these two bills that are the subject of this hearing today. As you know, S. 369 would alleviate the requirement of repayment to the U.S. Treasury of amounts ranging from \$1,455.66 to \$5,998.66 received by 13 physicians who are career members of the Senior Executive Service from the Department of Health and Human Services.

All of these executives received base pay, performance awards and physicians comparability allowances in aggregate amounts in fiscal year 1982 which exceeded the limitations which are set forth by 5 U.S.C. 5383 subsection (b) which is the rate payable for positions at Level I of the Executive Schedule.

This situation is a direct result of the retention of the Level I pay cap of \$69,630 when the SES pay cap was raised from a little over \$50,000 to \$58,500 on January 1, 1982. The cause of the overpayments for the 13 physicians is the SES performance award that each received in December 1981. Were it not for that performance award, the combination of base pay and physicians comparability allowance would not have exceeded the statutory limit of \$69,630.

The Department could have reduced their bonus payments to take into account the new base pay, but the Department was not certain what the new base pay levels would be that would be set by Congress. Also, because of an Office of Personnel Management policy which restricted payment of bonuses as well as a Presidential rank in the same year, our bonuses had to be paid no later than December 31 of that year. Had we made bonus payments for fiscal year 1981 performance in calendar year 1982, our very best executives would not have been eligible for consideration for rank awards.

The critical point, then, is that at the time the bonuses were paid to the 13 physicians in late December 1981, neither the employees involved nor the Department were certain what specific overpayments would result. When the potential overpayment situation was discovered, the Department sought a waiver from repayment for the affected executives through procedures established by the General Accounting Office.

In response to our request, the Comptroller General ruled that payments in excess of the statutory limit may not be waived by GAO. The GAO authority to grant a waiver applies only to claims of the Government arising out of erroneous payments.

Since the bonus payments that were issued were legal when they were issued and properly made, these payments were, therefore, not erroneous.

The waiver sought by the Department in behalf of the physicians was, therefore, not applicable. However, GAO did not object to the continued payments, which put the 13 physicians into overpayment status during the remainder of fiscal year 1982 provided repayment was eventually required by the Department.

Based on the GAO decision, I informed each of the affected executives of the requirement to repay the specified amounts to the U.S. Treasury. They were given until September 30, 1983, to make restitution, a timeframe provided to the Department by GAO.

To anticipate similar situations in the future, the Department has taken steps to monitor closely payments in excess of the base pay to SES members, particularly those receiving a PCA, to avoid this problem.

While the Department initially supported seeking administrative remedies in this situation, we do not support S. 369. The employees were aware that there were overall compensation limits at the time they received their bonuses.

This Department gave the individuals proper and timely notice and information that they were projected to receive compensation overpayments.

In regard to S. 1009, the Department would support a 2-year extension rather than a permanent extension of the authority. This would enable us and other agencies to monitor the supply of, and the demand for, Federal physicians.

I would be glad to answer any questions the committee may have on these two bills or any other issues related to my testimony.

Senator STEVENS. Thank you very much, Mr. Secretary.

First, let me see if my friend, Senator Mathias, wishes to make a statement.

OPENING STATEMENT OF SENATOR MATHIAS

Senator MATHIAS. I appreciate that, Mr. Chairman. I don't want to interrupt the testimony, but I would like to say just briefly that I thank you for holding these hearings on S. 369 and S. 1009 concerned with physicians in Federal service.

I introduced S. 1009 with the support and encouragement and sponsorship of the chairman on April 7. It would permanently reauthorize physicians comparability allowances, extending the authority for Federal agencies to enter into service agreements with Federal physicians.

As the chairman knows, we have wrestled with this recurrently, and we look for some more stable arrangement. The purpose is to provide additional compensation on top of basic pay to physicians in Federal service in order to resolve recruitment and retention problems. This was originally authorized in 1978, and since then, the agencies have had a means to encourage physicians to come into and to remain in the Federal service.

It is my understanding that the act has been successful as far as recruitment is concerned, and I hope that the witnesses this morning will confirm that.

The other bill, S. 369, is a very limited one. It deals with 13 specific doctors who have been overcompensated through no fault of their own.

Mr. Chairman, I will leave the balance of my statement for the record.

Senator STEVENS. Thank you. We will put it all in the record, Senator.

[Senator Mathias' prepared statement follows:]

PREPARED STATEMENT OF SENATOR MATHIAS

Mr. Chairman, I would like to commend you for holding this hearing on S. 369 and S. 1009, bills concerned with physicians in the Federal service.

I introduced S. 1009, with the Chairman's cosponsorship, on April 7 of this year. The bill would permanently reauthorize the Federal physicians comparability allowances, extending the authority for Federal agencies to enter into service agreements with Federal physicians.

The purpose of comparability allowances is to provide additional compensation, on top of basic pay, to the physicians in the Federal service in order to solve recruitment and retention problems which exist in the medical field. This program was originally authorized in 1978. Since then, agencies with recruitment and retention problems have had a means to encourage physicians to come into and remain in the Federal service by entering into these contracts which grant up to \$10,000 in comparability payments.

It is my understanding that the Physicians Comparability Allowances Act has been very successful in remedying recruitment and retention problems in the Federal Government. I look forward to having that confirmed by our witnesses this morning. It is imperative that the Federal Government be able to attract and retain the highly qualified physicians we have had in the past. Extending the Physicians Comparability Allowances Act will greatly assist that effort.

Mr. Chairman, the other bill before the Subcommittee today, S. 369, also deals with Federal physicians. However, this legislation is limited to 13 specific doctors who have received an overpayment of Federal compensation, through no fault of their own. S. 369 would waive the Senior Executive Service pay cap for these 13 physicians, but only to the extent of their individual overpayments in fiscal year 1982. It would thereby obviate the need for these doctors to repay the Federal Government in this one instance.

The Subcommittee has before it an able witness who is prepared to describe the particulars of how and why this overpayment occurred. I therefore will not go into that at this time. I will say, however, that this legislation is very important. The overpayments involved occurred because the physicians excelled in their work and were given performance awards pursuant to the Civil Service Reform Act of 1978. Requiring the repayment of those awards runs completely counter to the purpose for which they were authorized. Rather than rewarding excellence, the repayments would penalize excellence. The Congress must not allow this to happen.

Mr. Chairman, before I close, I would like to add one more thought for the Subcommittee's consideration. S. 369 is necessary because the physicians comparability allowances have been included in the aggregate compensation limitation for SES members set forth in 5 U.S.C. 5383(b). This limitation was not originally part of the Physicians Comparability Allowances Act, but was added at a later date when the allowances were reauthorized. The Act is intended to alleviate recruitment and retention problems. It authorizes a contractual payment of up to \$10,000. I believe that dollar limitation is sufficient. It is not necessary, nor is it prudent, to include the physicians comparability allowances in the overall SES compensation limitation. I will ask our witnesses today to address this point.

I conclude this morning by expressing my appreciation to the Chairman for allowing me the time to express my strong support for both pieces of legislation before us today.

Senator STEVENS. Mr. Secretary, what about the future? Should we exclude these bonuses from the statutory limitation in the future?

Mr. McFEE. Let me answer that question by giving you a little history of the section of title 5 that includes physicians comparabil-

ity as part of the overall aggregate amount that is used as the cap. That happens to be section 5383(b) of the Civil Service Reform Act.

The original Civil Service Reform Act did not include physicians comparability allowance as one of the items that was counted against the cap. It only included the Presidential rank awards; it included basic pay; and it included the performance bonuses. Early in the implementation of the Civil Service Reform Act, there was a question raised as to whether physicians comparability allowance was applicable to SESers.

If you remember, we were converting from the old super-grade system to the SES system. We did get a General Counsel ruling from the Office of Personnel Management that PCA could be given to SESers. That General Counsel ruling also said that even though the statute did not specifically include the PCA, that it was intended—or the intent of the legislation was to include it.

The modifications that were made in December 1979 which reauthorized the Physicians Comparability Act made very clear in the new PCA Act that SESers were included, and it added, at that time, in the statute, the fact that the section 5948 payment was included as part of the overall title 1 cap.

Senator STEVENS. Isn't it the bonus that is the problem rather than the physician's allowance? If the bonus was excluded from the cap, then there would be no uncertainty. As you point out in your statement, the Department could have reduced the bonus payment to take into account the new base pay, but the Department wasn't certain what the base level would be set by Congress.

Mr. McFEE. The bonuses are clearly included as part of that particular section.

Senator STEVENS. But that is not a question. What I am asking is should they be?

Mr. McFEE. Yes; I think they should continue to be included. I think excluding them for a particular part of the SES population would be a mistake. I don't think the inclusion of the bonuses is the problem; I think the inclusion of the PCA in the cap is what actually caused the problem.

If the \$10,000 that these gentlemen receive under the physicians comparability allowance had not been included in the cap, we could have paid the full bonuses.

Senator STEVENS. But you don't pay bonuses every year to these people, do you?

Mr. McFEE. Not to every individual, but if they are the top performers in the Department, the chances that they would be paid bonuses is pretty high.

Senator STEVENS. But the comparability pay is paid to everyone that comes in under its coverage, isn't it?

Mr. McFEE. That is correct.

Senator STEVENS. I don't know what the Senator believes, but my feeling would be to just exclude the bonuses, because that is the discretionary payment, and we count all of the nondiscretionary payments in there. We will explore it.

Senator MATHIAS. It seems to me that there is a large problem with this bonus program, not only in connection with the physicians, but throughout the Federal service. We have set up a bonus system, and then we have found all sorts of ways to negate them.

To make them useful and worthwhile, we either ought to have bonus systems or we oughtn't to have bonus systems.

The U.S. Ambassador to Moscow, just to give you an unrelated example, got one of the bonus awards, announced with a great flourish. He had been selected for this award, but then they said, "But under the existing pay restrictions, you can't get any of the money; you just get the honor."

Mr. McFEE. Mr. Chairman, if I could clarify something that I said when you asked me whether bonuses should be included under the cap, I was assuming that you meant excluding them for doctors or physicians only.

I believe this discussion may mean that you were interested in excluding them altogether from the cap. That is an absolutely different question.

Senator MATHIAS. Maybe I took the chairman further than he wanted to go, but I was just expressing a personal view on that. It is sort of silly to have them and then not pay them.

Senator STEVENS. I don't think that the base pay should have to be reduced because of a bonus.

We will explore it. One or the other, I think, has to be excluded for this to not happen in the future.

Do you have any other questions, Senator?

Senator MATHIAS. I am just wondering how much anticipation there was that these overpayments would result.

Mr. McFEE. We discovered that the overpayments occurred about 3 months after the bonus payments.

Senator MATHIAS. Retrospective and not prospective.

Mr. McFEE. Yes; we did not determine that prior to awarding the bonuses.

Senator STEVENS. But it was the bonus that put them over, wasn't it? It was not any other action of their own.

Mr. McFEE. Technically, it was the bonus that put them over, yes.

Senator MATHIAS. Were they given any options as events unfolded?

Mr. McFEE. After the fact; after we paid them all; I then wrote to each of them and told them that they could pay it back in a lump sum or we would take so much out of their pay each month.

I believe that each have opted to pay us back in a lump sum by September 30; so no repayments have been made yet.

Senator MATHIAS. It looks to me as though that makes the bonus a penalty, particularly if they have families who have pressing educational and other needs and they have spent the money, and now they have to dig it up and pay it back. It was not the intention of the Congress to impose penalties on these people; it was to reward the outstanding service, the initiatives, the special dedication and commitment they have demonstrated.

To do that by asking them to pay what really amounts to a penalty, it seems to me, is the reverse of what we hoped would happen.

Senator STEVENS. How much discretion is there in the comparability amount?

Mr. McFEE. The law allows us to pay up to \$10,000. We have a complex set of regulations to determine how much the various

people should get. I think our average—and by the way, we do not pay all of our doctors the comparability allowance.

In fact, within our Department this last year, we had 1,525 physicians and 577 of them get the comparability allowance.

It has averaged in our Departments somewhere from \$6,000 to \$7,000. The gentlemen that are in question under S. 369 all received, I believe, the full authorized \$10,000 because of their rank in their position and length of service and the length of the contract that they signed. There is an extra \$1,000 allowed within the \$10,000 for Board certification; there is an extra \$1,000 authorized if they sign a 2-year agreement to stay with us.

Senator STEVENS. I see.

Any other questions?

Senator MATHIAS. No.

Senator STEVENS. Thank you very much, Mr. Secretary.

Mr. James Morrison, Associate Director for Compensation of the Office of Personnel Management.

TESTIMONY OF JAMES W. MORRISON, JR., ASSOCIATE DIRECTOR FOR COMPENSATION, OFFICE OF PERSONNEL MANAGEMENT

Senator STEVENS. Good morning.

Mr. MORRISON. Good morning, Mr. Chairman, Senator Mathias. Thank you very much for the opportunity to present the administration's views on S. 369 and S. 1009, two bills concerning compensation for Federal physicians.

First, I would like to address S. 1009, a bill to make permanent the physicians comparability allowance program. When the Government has recruitment and retention problems caused by high, non-Federal pay for an occupation, the basic flexibility we have to rely on is our special rate authority, whereby we can increase pay rates for particular occupations by up to 30 percent if necessary. We have had special rates in effect for physicians for many years; yet there were still recruitment and retention problems in some cases.

As a result, the physicians allowance authority was established by Congress in 1978 to assist Federal agencies in their efforts to recruit and retain physicians under the General Schedule and certain other pay systems. The agencies may enter into individual service agreements with eligible physicians for their continued service in exchange for the payment of allowances of up to \$10,000 per year.

About 1,300 physicians are now serving under these agreements out of some 3,000 physicians employed under the covered pay systems. The average allowance is approximately \$8,600 per year. The authority was established on a temporary basis in 1978 and has been extended twice, in 1979 and again in 1981.

This administration supported the 1981 extension, since the program had proven valuable as a tool for the agencies to use when needed to deal with problems in recruiting and retaining physicians.

In preparation for this year's consideration of whether the allowance program should be extended again, the Office of Personnel Management has reviewed agency experience with the program.

With your permission, Mr. Chairman, I would like to submit into the record this report, a study that we have just completed.¹ It was done in anticipation of a September reauthorization.

In brief, we found that the need for the program continues, owing to continued difficulty in recruiting and retaining physicians and to the higher pay that is available to physicians outside the Federal Government, and in Federal agencies with separate authorities for physicians' bonuses. Some agencies' medical activities may be significantly hampered by the loss of the allowance authority.

However, the administration opposes making the program permanent, as would be provided by S. 1009. In our view, the possibility of changing conditions over time with respect to the recruitment and retention of physicians is just too great to justify a permanent authority. In particular, there will be a 43 percent increase in the U.S. physicians supply between 1978 and 1990. The Graduate Medical Education National Advisory Committee estimates that in 7 more years, the physician supply will total nearly 536,000 and will exceed the estimated need.

By 1990, moreover, approximately 40 percent of all practicing physicians will have entered practice since 1978. Based on this rapidly increasing supply of physicians, we do not expect agency recruiting difficulties will continue past the mid-1980's. We believe the proper approach is to again extend the program for 2 years. This period of time will allow agencies to make meaningful use of the authority, while also allowing appropriate review of the changing conditions that may affect the future need for the program. Among other things, agencies now carefully review the way in which physicians are used to make sure that they are employed in clinical and research settings where they are needed and that they do not occupy jobs in which nonphysicians can be used. Thus, we recommend that S. 1009 be amended to provide a simple 2-year extension rather than any longer period.

I would now like to turn to S. 369, a relief bill for 13 physicians who are members of the Senior Executive Service, the SES, employed by the Public Health Service in the Department of Health and Human Services.

For all members of the SES, aggregate compensation received during any fiscal year, including basic pay, bonuses, rank awards, and physicians allowances where applicable, may not exceed the rate payable for Level I of the Executive Schedule at the end of that fiscal year. The limit on SES compensation was included in the Civil Service Reform Act and has been a well-known and well-understood part of the SES compensation system from the start.

These 13 employees received both physicians allowances and SES bonuses between October and December 1981. Basic pay for the SES was increased on January 1, 1982, but the aggregate limit on SES compensation, that is, the Level I rate, was not increased. As a result, these individuals would have exceeded the \$69,630 aggregate limit on fiscal year 1982 SES compensation had they continued at full salary for the rest of the fiscal year.

¹ See p. 20.

This matter was presented to the Comptroller General by the Department of Health and Human Services, as a request to waive overpayments to the individuals involved. In August 1982, the Comptroller General ruled that the waiver provision was not applicable, because the overall cap for fiscal year 1982 had not yet been reached, and payments of basic pay could still be reduced to avoid any overpayment.

The Comptroller General also ruled that the plain language of the statute allows no exceptions from the aggregate limit.

While we certainly recognize the unhappiness these individuals feel over the situation, we must oppose S. 369 since we believe it would unfairly benefit these 13 individuals in relation to the many other SES members who have also had their aggregate compensation limited by the Level I ceiling. While the timing of payments in this particular case certainly created an awkward situation that we hope can be avoided in the future, we believe the key point to remember here is that the 13 individuals were each paid a total of \$69,630 during the fiscal year, equal to the highest amount received by any other SES member, and equal to the pay received by members of the President's Cabinet.

We cannot see any need or justification for relief in this situation.

Thank you, Mr. Chairman. I would be happy to answer any questions you or Senator Mathias may have.

Senator STEVENS. What is the average allowance? As I understand it, about half of the doctors receive allowances of approximately \$6,000.

Mr. MORRISON. The average, sir, the average Governmentwide, is about \$8,600, and we think that is about accurate in terms of its usage.

Senator STEVENS. That is an average when you consider the ones that are not receiving any, is it?

Mr. MORRISON. This is the average for those who are receiving an allowance, sir.

Senator STEVENS. But only about half of them are receiving it.

Mr. MORRISON. About 43 percent received an allowance, which suggests also that there are many instances where recruitment and retention is not a problem—that the agencies have determined that no allowance is necessary to recruit or retain these doctors in more than half of the cases.

Senator STEVENS. It has been an effective tool, hasn't it?

Mr. MORRISON. Yes, sir, where it has been needed, we think it has been effective, and we think the agencies have, in general, used it quite well.

Senator STEVENS. It is basically a retention tool, isn't it?

Mr. MORRISON. It is both a recruitment and a retention tool. It depends pretty much on the category of physician that an agency is dealing with, whether it is one in administration or one in research, for example.

In research, in many areas, the allowance is likely to be a recruitment tool.

Senator STEVENS. Why do you oppose some longer period than 2 years? We have got to look at this every 2 years? I just think there ought to be some concept of, if we are looking at the nineties,

saying we are going to have a surplus of doctors in the nineties, maybe 4 years or 5 years; but 2 years, you know, it just gets to be a matter of rote. If we are going to do it every 2 years, why not spread it out a little bit?

Mr. MORRISON. I certainly recognize the chairman's point. But as I said earlier, I think we are really concerned about this possibility of changing conditions that might make the allowance program unnecessary or certainly would suggest a need for some major modifications.

Senator STEVENS. All right. You are saying you expect a substantial change in the physician supply picture in the nineties, right?

Mr. MORRISON. By 1990, and even by the mid-eighties, it may well be that this allowance program either would border on being unnecessary or certainly should need some modifications.

We are also concerned about—we think it ought to be focused always on recruitment and retention, and we are really concerned about going down a road that suggests some automatic entitlement that raises peoples' expectations as a permanent authorization might do, and at least from our perspective—

Senator STEVENS. Well, I can see that no agreement should be beyond the 2-year period, but I don't know why the authorization has to stop at the end of that period.

Why can't we say a 4-year authorization but no agreement can be for longer than 2 years?

Mr. MORRISON. A simple 2-year extension, sir, would extend the authorization from September of 1983 to September 1985, and under that simple extension, it would allow contracts to be entered into as late as September 30, 1985, extending to 1987, so a simple, 2-year—

Senator STEVENS. The language says that you can't have an agreement entered into later than 1983 or the agreement can't cover a period of service extending beyond 1985 right now.

Mr. MORRISON. That is the current act right now, yes, sir.

Senator STEVENS. If we put 2 years on that, it would be it can't be entered into after 1985, and it can't have a period of service beyond 1987.

Mr. MORRISON. Yes, so that would, in effect, give you, for all intents and purposes, 4 years' coverage and take you close to the nineties.

Senator STEVENS. It would take you a lot closer if you made it [laughter] 1987 and 1989. That is right on the nineties.

Do you have any questions, Senator?

Senator MATHIAS. I would like to pick up the point that you have brought us to, Mr. Chairman; namely, what is the effect of this going to be on recruitment of physicians if we enact a limited program. If Federal physicians can only make the limited contracts and if the physicians are uncertain that they are going to be able to get comparable compensation under existing law, what's the result?

Isn't this going to have a somewhat depressing effect on both recruitment and retention?

Mr. MORRISON. I would think not, sir, given the fact that only about 43 percent of the eligible covered physicians today are actually receiving an allowance.

So well over half of the doctors in that part of the Federal service subject to this allowance authority are being recruited and retained without benefit of the payment.

Senator STEVENS. Have you got that broken down?

I would think that it may be easier to get physicians to come on board now than it is to retain them.

Mr. MORRISON. Again, sir, it depends on the occupation. I don't have that broken down by length of service for physicians. We would have to do a fairly extensive survey of the Department and agencies that use the authority to extract that.

But we do know in the aggregate that the allowances are used for under half of the physicians and, of course, we also know that on the average of those receiving it, even less than the full \$10,000 is used, an average of about \$8,600.

So we think the ramifications, any possible negative ramifications of a simple 2-year extension over permanent authorization are negligible.

Senator STEVENS. All right. What do you think about excluding either the bonuses or the allowances from the overall cap?

Mr. MORRISON. Well, sir, we would be opposed to that at the present time. The aggregate cap is set at Executive Level I, which is the highest salary for Presidential appointment or Cabinet level officials, and we think that that is well known and well understood. There are many cases where members of the Senior Executive Service, other than doctors—for example, anyone who is SES pay Level III and received a \$20,000 Presidential rank award, as Senator Mathias mentioned—are going to have some amount of that Presidential rank award reduced.

But on balance, we think, in terms of the general concern about the level of executive salaries in Government and at this point, we would think that the aggregate amount of the Level I cap, which is \$80,100, moved up from \$69,630 in 1982, is probably adequate to cover both bonuses and physicians comparability allowances.

Senator MATHIAS. But isn't there a certain amount of hypocrisy in setting up this system of bonuses and telling people that if they do a little bit of extra work for the Government and if they are a little smarter and a little more committed, they are going to be rewarded. But then when the bonus is won, we say, "Sorry, sorry, you won it, but you aren't going to get it." Isn't it better to just be honest with them and say, "We are not going to honor this commitment," and abandon it if we aren't?

Mr. MORRISON. I certainly understand the Senator's point of view on that, sir. I am not sure it is a matter of dishonesty since people know what their basic pay is, and they certainly know what their maximum is, under an \$80,100 cap.

So anyone who is smart enough to win a bonus knows that if they are already making \$67,000 and then they are getting—

Senator MATHIAS. So—and this ought to concern you—

Mr. MORRISON. It does.

Senator MATHIAS [continuing]. And the Office of Personnel Management—so if these employees are smart enough to know that they are going to hit the ceiling and not going to get an award payment, their response is going to be "just relax; don't put in that extra effort."

Senator STEVENS. They are smart enough to know that they can also make a lot more outside if they can figure that one out fast, too.

Mr. MORRISON. Yes, sir, I can certainly understand what you both are saying.

Senator MATHIAS. If what you are doing is stimulating more dedicated Federal service, it seems to me that we are going about it backward. I think that is all, Mr. Chairman.

Senator STEVENS. I think the witness may have a conflict of interest. He is one of those that couldn't get his bonus. Did you know that? [Laughter.]

Senator MATHIAS. I think we ought to express that.

Senator STEVENS. We will make this retroactive. [Laughter.]

Thank you very much.

Mr. MORRISON. Thank you, Mr. Chairman.

Senator STEVENS. Our last witness is Dr. Walter Barquist, Federal Physicians Association, president of the association.

TESTIMONY OF JOSEPH SMITH, M.D., CHAIRMAN, LEGISLATIVE COMMITTEE, FEDERAL PHYSICIANS ASSOCIATION

Dr. SMITH. Good morning, Mr. Chairman.

Senator STEVENS. Good morning.

Dr. SMITH. I am not Dr. Walter Barquist. He has had a death of a personal friend.

Senator STEVENS. Are you Dr. Smith?

Dr. SMITH. Yes.

Senator STEVENS. Sorry, Dr. Smith.

Dr. SMITH. And so he went to his funeral this morning, so I am taking his place.

Senator STEVENS. Then you are Dr. Joseph Smith, the chairman of the legislative committee of the Federal Physicians Association?

Dr. SMITH. Yes, sir.

Our Physicians Association is a national professional association representing medical doctors employed by the Federal Government in GS positions. In total, our group represents approximately 3,000 civil service physicians employed in some 36 agencies throughout the Federal Government, including the Federal prisons, mental institutions, the Indian Health Service, FAA, FDA, NIH, et cetera.

The Federal Physicians Association is happy to comment in favor of S. 1009, a bill to extend indefinitely and remove the expiration dates from the Federal Physicians Comparability Allowance Act of 1978, Public Law 95-603.

As the committee is aware, the purpose of this law is to foster a program intended to address the recruitment and retention problems which now exist among Federal physicians.

Specifically, the law has allowed Government agencies experiencing physician recruitment and retention problems to grant allowances to physicians who agreed to stay with the agency for a given period. The allowances cannot exceed \$7,000 per year for those with less than 2 years of service or \$10,000 per year for those with more than 2 years of employment.

Further, the act provides that without S. 1009, the authority to enter into these agreements will expire on September 30 of this

year and that no agreement with a physician signed before that date can be extended beyond September 30, 1985.

S. 1009 would make this program permanent. Without this legislation, the Federal Physicians Association is convinced that Government agencies presently employing Federal doctors would be at a serious disadvantage in competing for quality physicians in the labor market. We think that the approach taken in S. 1009—that is, making the allowance program permanent—is appropriate at this time.

The physicians comparability allowance has been in effect since 1979 and has more than shown its value and should be made a permanent compensation program.

I am going to digress just for a moment on that to say that the bonus, the physicians comparability allowance, is really an artificial approach to solving the problem of recruitment and retention. It really ought to be done with basic pay, partly because the allowance does not take retirement into consideration; also, with the way it goes on a 2-year basis, and so on, it does not give physicians much to go on if they are planning to join the Federal service; they can't count that that will always be there.

Once they decide to make a career out of it, it is rather demoralizing to find out that what they have based their careers on has now been pulled out from under them.

The record in favor of extending the Physicians Comparability Allowance Act, making it permanent, is clear and demonstrates that the physicians comparability allowance is vitally needed in order to retain competent Federal doctors in the Federal civil services.

As the committee knows, the physicians comparability allowance, first enacted in 1978, was most recently extended in December of 1981. At that time, the Office of Personnel Management urged Congress to extend the Federal program for an additional 2 years while reporting that implementation of the act in previous years had "significantly helped" Federal agencies in their recruitment and retention efforts of medical doctors.

The Department of Health and Human Services, in urging extension of the law, noted the discrepancy between private and public salaries for physicians as justification for the program.

They said,

The Physicians Comparability Allowance Act has helped alleviate the considerable disadvantage the Federal Government experiences in recruiting and retaining physicians.

The maximum salary the Federal Government can pay physicians is \$50,112. The maximum bonus payable under the act is \$10,000.

The total of \$60,112, now \$67,500, given the increase in the Federal pay ceiling, is subsequently below the national average for physicians in private practice which is reported to be a net of \$80,000.

The allowance has helped us to bridge some of that gap. It has demonstrated to physicians that the Government is aware of the problem and is taking some action in their behalf. Without an extension of the program, we are not only in danger of being unable to recruit qualified physicians, but also of losing our present staff of physicians to more lucrative positions in the private sector.

Since the time of the above statement, the national average for physicians salaries in private practice has grown higher, probably up to \$100,000 a year now, thus making permanent extension of

the Physicians Comparability Allowance Act more needed than ever.

In updating a study on recent agency experience under the physicians comparability allowance, I am personally aware that the report from St. Elizabeths Hospital and also from the Public Health Service strongly urges extension of the program. It is our understanding that data collected for the Office of Personnel Management from other agencies is also positive in terms of supporting an extension of the program.

One change, however, that the Federal Physicians Association would suggest, based on our experience under the Federal law, would be some minimum definition of recruitment and retention problems.

Under the Federal program, agencies are permitted wide discretion in determining exactly what constitutes a recruitment and retention problem for purposes of using the bonus program. Because of this discretion, wide variation in implementing the law has been observed among the numerous Federal agencies.

As a result, discriminatory and inconsistent implementation which we believe to be inconsistent with Congressional intent has been the result. There are numerous examples of such arbitrary implementation.

The FAA, Federal Aviation Administration, for example, has granted no comparability allowances whatsoever. This, in spite of vacancy rates among Federal flight surgeon positions approaching 20 percent over the last several years.

In some instances, institutions have differed in their awarding of comparability allowances to physicians of the same category and located in the same neighborhood.

Locally, for example, research physicians were originally offered comparability allowances by the National Institutes of Health, the Naval Medical Research Institute and the Walter Reed Army Institute of Research.

On the other hand, the Commander of the Walter Reed Army Medical Center refused comparability allowances to research physicians and all others within his command.

The worst problems occurred where installations have only a few physicians in a category or subcategories. This is the case at the Departments of Agriculture, Commerce, and Interior, to name just a few. Such physicians often occupy critical positions. They are difficult to replace and therefore vitally needed. So long as the incumbent stays in one place, the installation cannot demonstrate a recruitment and retention problem. Until he or she relocates, he or she will never receive a comparability allowance no matter how essential the position or how difficult it would be to fill it if it became vacant.

In commenting on this problem of discretion, the report of the House Subcommittee on Post Office and Civil Service in reporting the extension legislation in 1981 noted,

The committee has observed that implementation of the special allowance provisions of the Federal Physicians Comparability Allowance Act has been inconsistent among the Federal agencies. In some cases, agencies have granted the full allowance to all of their physicians while in other cases no allowance has been granted at all in spite of serious recruitment and retention problems. Therefore, the Committee

urges the Office of Personnel Management and those agencies employing Civil Service physicians to examine more closely the recruitment and the retention problems that exist with respect to these physicians and to make use of the allowance authorized by the act where identifiable problems exist.

Similar language was used by you, Mr. Chairman, in reporting the 1981 extension to the Senate floor.

To solve these problems, the Federal Physicians Association recommends that the bill be amended to require agency heads to demonstrate an absence of a recruitment or a retention problem in their agencies before denying agency physicians the bonus.

This finding would be based on specific criteria defining recruitment and retention problems as determined by Congress.

By defining a recruitment and retention problem as a specific, say, for example, 5 percent over a period of 6 months, inconsistency and variation in the use of the law would be greatly reduced. This 5-percent rate would be a trigger, then, for using the bonus allowance.

However, we would emphasize that such a trigger would not necessarily preclude continued use of the bonus at vacancy rates of less than 5 percent in instances where the bonus is being used as a preventative measure to avoid continued recruitment and retention problems.

The trigger would be used when an agency on its own, such as the FAA, has failed to implement the law even in the face of serious recruitment and retention problems.

In summary, Mr. Chairman, notwithstanding the above problems in agency discretion, the Federal Physicians Association wishes to underscore the overriding value of the Federal Physicians Comparability Allowance Act. We should always remember the benefit to the public derived from recruiting and retaining competent physicians in the Federal service. These physicians perform vital functions such as research in occupational medicine for the Center for Disease Control and the Food and Drug Administration. It was a Federal physician, for example, who originally discovered the potential public risk associated with the proposed introduction of thalidomide into the U.S. drug market. Without this doctor's vital work, a serious national health tragedy would not have been avoided.

We need to continue to attract and retain quality medical specialists in order to foster the promotion of the public health and well-being. The passage of S. 1009 will help guarantee this service to the public.

We appreciate the opportunity to appear before this Committee and will be happy to provide any additional information which the Committee may desire for the record.

I will be happy to answer any questions the Committee may have at this time.

Senator STEVENS. Do you know what the average grade is for physicians?

Dr. SMITH. I can't be accurate on that, but as for the physicians in my acquaintance, it would be close to GS-14's and GS-15's.

Senator STEVENS. I see. Do you have any figures on the average income for physicians in private practice?

Dr. SMITH. I understand private practice does close to \$100,000 a year nowadays.

Senator STEVENS. We did try to get the FAA to use the allowance program. As I understand your statement, that has not been successful.

Dr. SMITH. So far as I know, it has not been implemented yet.

Senator STEVENS. I appreciate your statement, and it is my judgment that the program has worked. We will attempt to poll S. 1009 out of the committee and fold into it partially the provisions of S. 369. I feel, as I indicated, that we ought to do a 4-year extension rather than a 2-year extension so that we just don't have to address this problem every 2 years. I think there would be a little bit better feeling out there in the community if they knew it was longer than 2 years, and with the opposition to a permanent allowance program, it would, I think, be stretching it to try and take it that far.

Dr. SMITH. May I make one more comment?

Senator STEVENS. Certainly.

Dr. SMITH. I am president of the Association of Physicians of St. Elizabeths Hospital which has about 250 physicians, so I am in fairly close contact with Federal physicians on a personal daily basis who are continually asking me questions about what the future, for example, of that hospital is, and what their future is in Federal service.

They are always concerned about whether the bonus will be renewed; whether they will be able to continue to make the commitments or keep up with the commitments they have made financially in the past where before they had counted on the bonus.

Senator STEVENS. The bonus or the allowance?

Dr. SMITH. The allowance, excuse me, which we call a bonus. But one of the things that I see is that physicians or any employees get demoralized when people are fooling around with their paycheck. I think it's really easier to concentrate on the job that you have got at hand if you never have to wonder what is going to happen this year or the next in regard to your pay. So that is why, as a Federal physician, my recommendation is not only that you consider a 4-year extension but certainly the idea of a permanent one, because as long as that element exists, that a person cannot go into more than a 2-year contract, there is nothing against having that extended permanently because the check on it is always the fact that you can't enter into more than a 2-year agreement.

Senator STEVENS. So if I understand your position on this, it is that you would like to see this extended for more than 2 years.

Dr. SMITH. I would really highly recommend that it be made on a permanent basis. Thank you.

Senator STEVENS. We have that recommendation with the opposition that has been received by the committee. I just don't think it would get through the Senate. If there is no further testimony, we will recess this hearing and direct the staff to prepare the bill to poll it out.

Thank you all very much.

Senator STEVENS. The subcommittee will now adjourn.

[Whereupon, at 11:05 a.m., the subcommittee was recessed, subject to the call of the Chair.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

98TH CONGRESS
1ST SESSION

S. 369

For the relief of certain Government physicians who were paid basic pay, performance awards, and physicians comparability allowances in aggregate amounts exceeding the limitation set forth in section 5383(b) of title 5, United States Code.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 1 (legislative day, JANUARY 25), 1983

Mr. MATHIAS introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

A BILL

For the relief of certain Government physicians who were paid basic pay, performance awards, and physicians comparability allowances in aggregate amounts exceeding the limitation set forth in section 5383(b) of title 5, United States Code.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*
- 3 That (a) notwithstanding section 5383(b) of title 5, United
- 4 States Code, the aggregate amount paid for fiscal year 1982
- 5 under sections 4507, 5382, 5384, and 5948 of such title to
- 6 an individual specified under column I below may exceed the
- 7 amount of the annual rate payable for positions at level I of

- 1 the Executive Schedule in effect at the end of such fiscal year
- 2 by not more than the amount specified under column II
- 3 below opposite the name of such individual:

Column I:

Column II:

Dr. Larry Silver.....	\$1,988.66
Dr. Louis Sokoloff.....	\$5,988.66
Dr. Ichiji Tasaki.....	\$1,488.66
Dr. Paul D. Parkman.....	\$1,455.46
Dr. Allan Forbes.....	\$1,680.91
Dr. Roscoe Brady.....	\$1,488.66
Dr. Martin Cummings.....	\$3,988.66
Dr. Manning Feinlieb.....	\$1,488.66
Dr. D. C. Gajdusek.....	\$1,488.66
Dr. Carl Kupfer.....	\$1,988.66
Dr. Toichiro Kuwabara.....	\$1,488.66
Dr. Lester Salans.....	\$1,488.66
Dr. Henry Webster.....	\$1,488.66

- 4 (b) Subject to the limitation on aggregate amounts com-
- 5 puted under subsection (a), the amount of any overpayment
- 6 under section 5383(b) of title 5, United States Code, col-
- 7 lected during fiscal years 1982 and 1983 from any individual
- 8 specified in subsection (a) shall be paid to such individual.
- 9 (c) For the purposes of the Internal Revenue Code of
- 10 1954, any amounts paid for fiscal year 1982 under subsec-
- 11 tions (a) and (b) of this Act shall be deemed to have been paid
- 12 on the date such amounts would have been paid but for the
- 13 limitation set forth in section 5383(b) of title 5, United States
- 14 Code.

98TH CONGRESS
1ST SESSION

S. 1009

To reauthorize Federal physicians comparability allowances.

IN THE SENATE OF THE UNITED STATES

APRIL 7 (legislative day, APRIL 5), 1983

Mr. MATHIAS (for himself and Mr. STEVENS) introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

A BILL

To reauthorize Federal physicians comparability allowances.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That section 5948 of title 5, United States Code, is amended
4 by striking all of subsection (d) and inserting in lieu thereof
5 the following new subsection (d):

6 “(d) Any agreement entered into by a physician under
7 this section shall not be for a period longer than two years.”.

Physicians Comparability Allowance Program Study

May 1983



**United States Compensation
Office of Personnel
Management Group**

PHYSICIANS' COMPARABILITY ALLOWANCE PROGRAM STUDY

I. BACKGROUND

Bonus pay for Federal physicians may be traced back to the post-Vietnam repeal of the military draft. Loss of that recruitment and retention tool for military physicians prompted passage of training legislation which provided a government-paid medical school education in exchange for obligated service. When this program failed to produce as extensive a selection as anticipated, other solutions were explored; bonuses which had been used successfully for pilots and other scarce skill Defense occupations were considered and implemented.

Soon after, the Veteran's Administration requested legislation to permit payment of bonuses to their physicians. VA argued they now had to compete not only with private sector pay, but also with DoD pay. Thus, a bonus program for Department of Medicine and Surgery (DM&S) physicians was instituted on a temporary basis and, subsequently, (two years ago) made permanent.

The Federal Physicians Comparability Allowance Act of 1978 established bonuses for General Schedule (and certain other pay plan) physicians. It was set up on a temporary basis and has been renewed twice. Current legislation expires on September 30, 1983; however, agreements entered into by that date may extend to September 30, 1985.

II. LEGISLATIVE DETAILS

Regulatory responsibility for this program is vested with the President who delegated it to OPM "in consultation" with OMB. Prior to using PCAP, agencies are required to submit a plan for OMB approval detailing their proposed use of the program.

The law allows for payment of special allowances to deal with recruitment and retention problems. They are required to be fixed at the minimum amounts necessary to solve such problems. However, the amount may not exceed \$7,000 per annum for those who have served as Government physicians for 24 months or less, and \$10,000 per annum for those having served more than 24 months.

Pay plans covered by this act are:

- General Schedule;
- Senior Executive Service;
- Merit Pay System;
- Administratively determined pay for certain specially qualified scientific or professional personnel;
- Tennessee Valley Authority Act;
- Foreign Service Act;
- Central Intelligence Agency Act;
- Panama Canal Act; and the
- National Security Act.

The head of an agency may enter into a service agreement with a physician which prescribes the length and amount of allowance as well as terms under which: (1) the agreement may be terminated; and (2) the allowance must be refunded.

The head of each agency must determine categories of physician positions for which there is a significant recruitment and retention problem. These categories must include at least the following four:

- (1) Category I: Positions primarily involving the practice of medicine or direct service to patients, including performance of diagnostic, preventive, or therapeutic services to patients in hospitals, clinics, public health programs, diagnostic centers, and similar settings, but not including positions described in paragraph 3 below. (For purposes of abbreviation, this category shall be referred to in this study as "clinical.")
- (2) Category II: Positions primarily involving medical research and experimental work including medical work pertaining to food, drugs, cosmetics, and devices; or identification of causes or sources of disease/disease outbreaks. (This category shall be referred to as "research.")
- (3) Category III: Positions primarily involving evaluation of physical fitness; or provision of initial treatment of on-the-job illness/injury; or performance of pre-employment or fitness-for-duty examinations, or preventive health screenings. (This category shall be referred to as "physical fitness.")
- (4) Category IV: Positions not described above including disability evaluation/rating; medicolegal autopsies, training activities, and administration of patient care, research/experimental, or any other medical/health program. (This category shall be referred to as "administration.")

Subcategories of the above four may also be established.

III. ANALYSIS

1980 was the first year in which PCA user data was collected. Table A lists staffing data for 1980, 1981 and 1982 broken out by the four major PCA categories and by grade. Although data varied from year to year, some general trends are apparent. The vast majority of Federal physicians (from two-thirds to three-quarters) worked as Category I clinicians. Almost all Category II researchers received bonuses; this is understandable since highly trained and experienced physicians are required in research and this is the group best able to command larger salaries. About one-half of the total number of PCA's went to clinicians, one-third to researchers, and fifteen percent to the other two categories combined.

Total PCA cost for 1982 is distributed among the four categories in these approximate amounts:

Category I	Clinicians	\$7,368,641
Category II	Researchers	1,540,520
Category III	Physical Fitness Evaluators	1,712,886
Category IV	Administrators	339,345
	Total	\$10,961,392

The total number of physicians on board has fluctuated slightly since 1980. A declining pattern is seen for clinical and research physicians, while Category III physical fitness evaluators have grown, particularly in 1982. Category IV, administrative physicians, has fluctuated slightly, but these physicians are only one to five percent of the total.

Physicians were granted special salary rates in 1955 and every year since that time. As it became obvious in recent years that clinical physicians were suffering more severe staffing problems than non-clinicians, the single medical officer special salary rate authorization was separated into two authorizations. This occurred on February 21, 1982 when higher special rates were allowed for clinical physicians. Upon review last October, their special rates were again increased while non-clinical rates remained unchanged. At the present time, however, there is very little latitude for providing significantly greater increases for physicians through the special rate program. The current authorizations permit clinical and non-clinical physicians to enter at the following steps for each respective grade level.

	<u>Clinical</u>	<u>Non-Clinical</u>
GS-11	Step 10 (of 10/82 schedule)	Step 9 (of 10/81 schedule)
GS-12	Step 10 (of 10/82 schedule)	Step 9 (of 10/81 schedule)
GS-13	Step 10 (of 10/82 schedule)	Step 9 (of 10/81 schedule)
GS-14	Step 9 (of 10/82 schedule)	Step 7 (of 10/81 schedule)
GS-15	Step 6 (of 10/82 schedule)	Step 4 (of 10/81 schedule)

TABLE A
HISTORICAL STAFFING DATA

	1980			
	Category I (Clinical)	Category II (Research)	Category III (Phys. Fitness)	Category IV (Administration)
On Board/%	1,541/75%	320/16%	136/7%	27/1%
Vacancies	228	17	9	5
Turnover Rate	31%	8%	12%	25%
Quit for Pay Rate	9%	1%	1%	15%
Staffing Success Rate	60%	84%	75%	50%
No./% Receiving PCA	647/42%	307/96%	N/A	7/26%
% of PCA Population	N/A	N/A	N/A	N/A
1981				
On Board/%	1371/71%	316/16%	144/7%	92/5%
Vacancies	211	35	19	11
Turnover Rate	19%	7%	14%	17%
Quit for Pay Rate	1%	3%	1%	8%
Staffing Success Rate	43%	63%	77%	40%
No./% Receiving PCA	544/40%	306/97%	75/52%	79/86%
% of PCA Population	54%	30%	7%	8%
				1,923/100%*
				276
				17%
				2%
				42%
				1,004/52%
				100%*

1982

	Category I (Clinical)	Category II (Research)	Category III (Evaluation)	Category IV (Administration)	Overall
On Board/%	1368/67%	286/14%	318/17%	63/3%	2,035/100%*
Vacancies	459	41	14	16	530
Turnover Rate	22%	7%	17%	17%	19%
Quit for Pay Rate	8%	3%	0%	1%	6%
Staffing Success Rate	37%	42%	88%	38%	41%
No./% Receiving PCA	474/35%	274/96%	84/26%	25/40%	857/42%
% of PCA Population	55%	32%	10%	3%	100%*

* Totals may not equal sum of subunits because of rounding.

Current PCA Data and Analysis

Our review of the need to seek renewal of PCA legislation focused on information used in the October 1982 review of the special rates for Medical Officers, supplemented by information from all agencies employing physicians. Table B lists the current physician population by agency, showing total population, PCA population, average PCA amounts, and agency recommendation regarding continuation of the PCA Program. The data is current as of March 1983. To the best of our knowledge, this is a complete list of agencies employing Federal physicians under the General Schedule and certain other allied pay plans. For the most part, they are eligible for both special salary rates and PCA. (See footnotes for exceptions.)

HHS is the largest employer of GS-602, Medical Officers. A large majority of them exist in the U.S. Public Health Service, covering such agencies as NIH, Indian Health Service, FDA, etc. The Armed Forces are the next largest employers, supplementing their military cadre of physicians with almost one thousand civilian doctors. VA employs over 100 GS doctors to process their disability claims; most are GS-12's and receive no PCA. (The vast majority of VA physicians, however, are not listed here; they are employed under title 38, Department of Medicine and Surgery Pay Plan, which contains its own bonus and special rate system.) All other agencies employ approximately 50 or fewer physicians each.

Of the agencies using PCA, most supply bonuses to one-half or more of their doctors. However, the largest employer, HHS, currently limits its PCA population to 41 percent. Agency PCA averages vary from \$6,000 to \$10,000; the overall weighted average is approximately \$8,570.

All agencies using PCA (plus seven who currently do not) are in favor of its continuation; eight are neutral; no agency is opposed to its renewal. Some agencies noted specific conditions or medical areas which caused particular difficulty. Agriculture, AID, and NIH expressed most concern about research positions. NIH asserted that only a small percentage of the nation's physicians are capable of conducting first class research and the government must compete for their skills with private research companies, as well as with medical schools. Army and Defense were most concerned about their ability to hire and retain certain specialties, e.g., radiology, otolaryngology, and orthopedic surgery. Working in remote areas caused concern at Army, Defense, and Agriculture (Grand Forks, North Dakota); doctors are not typically inclined to locate in these areas. NASA says that recruiting for aerospace medicine and research is always difficult because very few physicians qualify for this new field of medicine.

TABLE B
CURRENT PHYSICIAN/PCA POPULATION, MARCH 1983

<u>Agency</u>	<u>No. on Board</u>	<u>No./Percent Receiving PCA</u>	<u>Average PCA</u>	<u>Agency Recommendation</u>
HHS	1,577	643/41%	\$8,912	PRO
Army	656	338/52%	7,695	PRO
Air Force	207	127/61%	8,634	PRO
VA	127	0	----	PRO
Navy	96	47/49%	8,234	PRO
State	56*	56/100%	9,314	PRO
Justice	56	48/86%	9,500	PRO
Transportation	40	0	----	PRO
NASA	32	0	----	PRO
AID	24*	0	----	PRO
Soldiers/Airmen Home	15	0	----	PRO
TVA	15*	0	----	PRO
Labor	10	2/20%	10,000	PRO
EPA	8	4/50%	10,000	PRO
Energy	8	0	----	NEUTRAL
Peace Corps	8*	0	----	NEUTRAL
DOD (NSA)	7*	7/100%	6,143	PRO
OPM	7	0	----	PRO
Agriculture	5	4/80%	10,000	PRO
Panama Canal	3*	2/67%	10,000	PRO
GPO	2	0**	----	NEUTRAL
Education	2	0	----	NEUTRAL
Interior	2	0	----	NEUTRAL
GAO	1*	1/100%	6,000	PRO
Consumer Product Safety Comm.	1	0	----	NEUTRAL
Treasury	1	0	----	NEUTRAL
Commerce	0***	0	----	NEUTRAL
Total	2,966	1,279/43%	\$8,570	

* Not covered by special salary rates.

** Not covered by PCA.

*** When OMB disapproved their request for PCA in 1979, Commerce contracted the work of their one medical officer position.

Table C provides staffing data by grade and PCA categories. The data is current as of June 1982 when it was last collected in sufficient detail to compute staffing rates. Since such detailed reports were required last summer and would be developed again this summer for the special salary rate program, we decided not to require total reporting for purposes of this study. Instead, agencies were asked to report only major changes since June 1982. HHS reported an additional 679 positions which has been inadvertently omitted last June and DoI reported a loss of three of their 13 positions. As a result, it should be noted when reading Table C that specific data for this table is missing for almost one-third of the physicians. HHS could give us no further facts other than their knowledge that 10 percent of this missing group received PCA's. The other five major PCA-using agencies reported no significant change since June 1982.

Vacancy, turnover, and quit for pay rates show that clinicians suffer the largest staffing problems, followed closely by administrators, then researchers, and, finally, physical fitness evaluators. It appears that clinical and administrative positions in the Federal Government are viewed as less desirable than research and fitness evaluation positions. In clinical work, probably both pay and work experience are causative factors; private practice usually provides greater income and often broader work experience. The quit for pay rate at 8 percent is highest in the clinical category. OPM's Washington Area Office which maintains the GS-602 Medical Officer register, verifies that clinical certificates of eligibles are requested more often than non-clinical certificates.

Government research work, on the other hand, can provide unique opportunities to do significant research for which some physicians are willing to take a cut in pay during at least a portion of their career. The main attraction of fitness evaluation work is less stress and responsibility than private practice, e.g., avoiding long work weeks and susceptibility to malpractice suits. Thus, this category often appeals to older physicians who wish to relinquish their private practice. Advanced age would help to explain why this category experiences its largest vacancy rate at GS-15 where retirement is a major reason for leaving. The other three categories experience the greatest vacancy rates at their entry levels: GS-11 and GS-12 for clinicians, GS-13 and GS-14 for researchers, and GS-13 for administrators.

The most striking data are the very low staffing success rates. This rate measures the number of vacancies filled compared with the number the agency tried to fill. Clinicians and administrators have staffing success rates of only 37 percent and 38 percent, respectively. The rate for researchers, while a little higher at 42 percent, still shows a serious recruitment problem. Only Category III, physical fitness evaluation, shows a somewhat acceptable staffing success rate of 88 percent. In fact, Category III is the only one whose various staffing rates fall within healthy boundaries for the most part. Interestingly, this is also the category with the lowest percentage of PCA recipients (26%). Thus, physical fitness evaluation seems to be a line of Government medical work sufficiently attractive for reasons other than pay. The other three categories cannot do better than fill 4 out of every 10 vacancies at this time. The trend has been downward during the past three years, going from a staffing success rate of 60 percent to 37 percent in Category I, from 84 percent to 42 percent in Category II, and from 50 percent to 38 percent in Category IV despite special salary rates and PCA. The benefits of PCA were greatest soon after its inception, but have been deteriorating ever since.

TABLE C
CURRENT STAFFING DATA, JUNE 1982

	<u>GS-11</u>	<u>GS-12</u>	<u>GS-13</u>	<u>GS-14</u>	<u>GS-15</u>	<u>Total</u>
<u>Category I (Clinical)</u>						
On Board	30	113	622	526	77	1,368
No./% Receiving PCA	7/23%	13/12%	157/25%	250/48%	47/61%	474/35%
Vacancy Rate	42%(22)	48%(103)	19%(149)	25%(179)	7%(6)	25%(459)
Turnover Rate	30%	24%	21%	21%	26%	22%
Total Quit for Pay Rate	13%	2%	6%	10%	22%	8%
PCA Quit for Pay Rate	0%	8%	4%	5%	2%	4%
Staffing Success Rate	0%	37%	44%	33%	50%	37%
<u>Category II (Research)</u>						
On Board	--	4	22	88	172	286
No./% Receiving PCA	--	3/75%	19/86%	83/94%	169/98%	274/96%
Vacancy Rate	--	0%(0)	19%(5)	19%(20)	9%(16)	13%(4)
Turnover Rate	--	0%	9%	6%	8%	7%
Total Quit for Pay Rate	--	--	5%	5%	3%	3%
PCA Quit for Pay Rate	--	--	0%	4%	3%	3%
Staffing Success Rate	--	--	20%	50%	41%	42%
<u>Category III (Physical Fitness)</u>						
On Board	--	177	41	58	42	318
No./% Receiving PCA	--	55/31%	13/32%	13/22%	3/7%	84/26%
Vacancy Rate	--	3%(5)	2%(1)	6%(4)	9%(4)	4%(14)
Turnover Rate	--	13%	7%	9%	21%	13%
Total Quit for Pay Rate	--	0%	0%	2%	0%	1%
PCA Quit for Pay Rate	--	--	--	0%	--	0%
Staffing Success Rate	--	80%	100%	67%	100%	88%

	<u>GS-11</u>	<u>GS-12</u>	<u>GS-13</u>	<u>GS-14</u>	<u>GS-15</u>	<u>Total</u>
<u>Category IV (Administration)</u>						
On Board	--	0	9	28	26	63
No./% Receiving PCA	--	--	3/33%	8/29%	14/54%	25/40%
Vacancy Rate	--	100%(1)	47%(8)	13%(4)	10%(3)	20%(16)
Turnover Rate	--	100%	22%	4%	2%	21%
Total Quit for Pay Rate	--	0%	11%	0%	0%	2%
PCA Quit for Pay Rate	--	--	0%	--	--	0%
Staffing Success Rate	--	0%	0%	80%	14%	38%
<u>All Categories</u>						
On Board	30	294	694	700	317	2,035
No./% Receiving PCA	7/23%	71/24%	192/28%	354/51%	233/74%	857/42%
Vacancy Rate	42%(22)	27%(109)	23%(163)	30%(207)	9%(29)	26%(530)
Turnover Rate	30%	17%	20%	18%	15%	18%
Total Quit for Pay Rate	13%	2%	5%	8%	7%	6%
PCA Quit for Pay Rate	0%	8%	4%	4%	3%	3%
Staffing Success Rate	0%	47%	46%	36%	48%	41%

Table D describes the distribution of the PCA population by category, grade and amount of bonus. The majority of allowances fall in the \$7,001-\$10,000 range. This is true for categories I, II, and IV and for the grand total; category III has the majority of allowances (62%) in the \$5,001-\$7,000 range. This is as one would expect, i.e., the category with the least staffing problem offers the lowest allowance. GS-14's receive 37 percent of all PCA's and GS-15's receive 30 percent. In individual categories, however, majority grades range as follows: I--GS-14; II--GS-15; III--GS-12; IV--SES. Again, such a breakout is not surprising; it flows from lowest graded work (physical fitness evaluation) to highest graded work (administration). Distribution by category shows 55 percent of the PCA population in Category I, 26 percent in Category II, 11 percent in Category IV and 8 percent in Category III. Clinicians have always been in the majority in the Federal physician work force.

TABLE D

PCA POPULATION DISTRIBUTION BY CATEGORY/GRADE/AMOUNT

<u>Category I (Clinical)</u>	<u>Under</u> <u>\$2,500</u>	<u>\$2,501-</u> <u>5,000</u>	<u>\$5,001-</u> <u>7,000</u>	<u>\$7,001-</u> <u>10,000</u>	<u>Total**</u>	
GS-11	*	*	1%	--	1%	
GS-12	*	*	*	1%	2%	
GS-13	*	2%	6%	17%	26%	
GS-14	*	4%	9%	37%	49%	
GS-15	*	2%	2%	17%	21%	
SES	--	--	--	*	*	
Total**	1%	9%	18%	72%	100%	
<u>Category II (Research)</u>						
GS-11	--	--	--	--	--	
GS-12	1%	*	--	--	1%	
GS-13	*	6%	1%	1%	7%	
GS-14	*	3%	4%	22%	29%	
GS-15	--	--	2%	59%	61%	
SES	--	--	--	2%	2%	
Total**	1%	9%	6%	83%	100%	
<u>Category III (Physical Fitness)</u>						
GS-11	--	--	--	--	--	
GS-12	--	17%	44%	--	61%	
GS-13	1%	6%	7%	4%	18%	
GS-14	--	2%	10%	6%	18%	
GS-15	--	--	1%	2%	3%	
SES	--	--	--	--	--	
Total**	1%	25%	62%	12%	100%	
<u>Category IV (Administration)</u>						
GS-11	--	--	--	--	--	
GS-12	--	--	--	--	--	
GS-13	--	--	1%	--	1%	
GS-14	1%	2%	3%	3%	9%	
GS-15	--	1%	--	16%	16%	
SES	1%	--	1%	72%	74%	
Total**	2%	3%	5%	91%	100%	
<u>Grand Totals:**</u>						
By Amount	1%	9%	17%	72%	100%	
By Grade	GS-11 1%	GS-12 6%	GS-13 18%	GS-14 37%	GS-15 30%	SES 9%
By Category	55% (I)	26% (II)	8% (III)	11% (IV)		

* Less than 1%.

** Totals may not equal sum of subunits because of rounding.

Register/Labor Market

The Washington Area Office (WAO) is responsible for maintaining the nationwide GS-602, Medical Officer register. As of March 18, 1983, it contained 691 names on 21 separate specialty registers, five of which are broken down further into an additional 27 subspecialties. Since some applicants qualify for more than one of the register categories, the 691 name listings actually represent only about 300 physicians. The problem is not one of an overall shortage, as much as an inadequate applicant supply for certain positions and areas. WAO maintains that when an applicant views the whole job package of: location; salary; fringe benefits; image (institution reputation); and work experience challenges, many Federal positions, such as prisons and Indian Health Service facilities, do not fare well. On the other hand, certain agencies such as the National Institutes of Health (NIH) and Federal Aviation Authority (FAA), which are pace setters in medical research and aviation medicine, are seen as attractive work experiences by many doctors.

Agencies complain it is difficult to get quality people to apply. They argue that most applicants are either very young and inexperienced, or old, not up-to-date in their medical skills and unwilling to stay on the job for long. Actually, an analysis of applicant age shows that: 45 percent are in the middle age group (36-55); 42 percent are 56 years and older; and 10 percent are 35 or younger. The test score distribution on a scale of 0-100 is as follows: 10 percent scored from 70-79; 26 percent from 80-89; and 64 percent scored 90 or above. Thus, the majority of applicants on the register are in: (1) the middle age group; and (2) the highest score group, which contradicts some of the agency arguments.

Some of their other arguments, such as short tenure of new hires, and "outdated" knowledges and skills may have validity. (The rating system gives more credit to older physicians' length of experience, even though some of their knowledges may be outdated in the opinion of some.) When agency needs are not met by the register, they sometimes request certification of non-citizen applicants. Such applicants are seen as desirable because of their greater availability and willingness to accept the more "undesirable" positions. (Of course, the agencies must document their unsuccessful effort to fill a position with a citizen before a non-citizen may be certified. Most non-citizen applicants are found to be qualified.)

Veteran status is not an issue on the GS-602, Medical Officer, register; veterans do not block the register. DOD and PHS have been given direct hire authority and maintain their own registers. VA, of course, has its own Department of Medicine and Surgery (DM&S) hiring authority under title 38.

The GS-602, Medical Officer Series, Qualification Standard is currently being rewritten. The draft standard proposes decreasing the amount of training/experience by one year for GS-13, 14, and 15. This could improve the staffing situation. However, another draft proposal would raise the criteria for demonstrating superior achievement and ability in post-graduate training to the upper 25 percent of all interns and residents, instead of the upper half; this could make recruitment more difficult.

IV. SALARY DATA ON FEDERAL AND PRIVATE SALARIES.

An attempt was made to obtain the best salary data available for inclusion in Tables E and F which compare various Federal and private sources of salary information. There are limitations to the usefulness of the data. For example, comparison is made difficult by the lack of uniform time frames. Other limitations are discussed below. The various sources of information are as follows:

- The State of Michigan, Department of Civil Service, conducts an annual compensation survey which includes four levels of physicians equivalent to the Federal GS-602 series at grades 12, 13, 14 and 15. Thirty-one counties and eight surrounding states participated in the survey. These rates have been in effect since October 1, 1981, because of a freeze on state salaries which would normally have increased in October 1982.
- Salaries listed by the American Medical Association's Socio-economic Monitoring System are based on reports from office-based, self-employed physicians. Their incomes are reported as net after expenses, but the survey information does not indicate what is included in expenses. This source also indicates that the pay of all physicians increased by an average 8.7 percent annually from 1975 to 1981.
- The 1981-82 medical school faculty salaries report published by the Association of American Medical Colleges (AAMC) contains data obtained from questionnaires mailed to 119 of the 126 fully and provisionally accredited public and private medical schools in the United States. The study does not indicate what proportion of physicians returned the questionnaires. It provides: (1) base compensation alone; (2) base and supplemental compensation; and (3) outside income added to both base and supplementary compensation. This breakout facilitates comparison with some of the various categories of Federal physician pay.
- The VA commissioned a study by compensation consultants Towers, Perrin, Forster and Crosby (TPFF&C) entitled "Report on Adequacy of Special Pay for Physicians and Dentists," March 1, 1983. It compared pay for VA and other Federal physicians with private sector pay as listed in Table E. VA's DM6S physicians and dentists appointed under title 38, USC are entitled to special pay based on the following categories: primary special rate; full-time status; tenure; medical specialty with extraordinary recruitment/retention difficulties; higher grade levels; specialty or board certification, and geographic location. In this way basic pay may be increased anywhere from \$13,000 to \$33,000 per year. This compares to increases of from \$2,800 to \$21,000 for GS physicians eligible for special rates and PCA. The VA salaries include base pay, special pay and outside remuneration averaging \$1,400. (Outside remuneration is not included in the salaries listed for other Federal physicians.)

- The General Schedule average salaries reported in Table E reflect the increase granted in October 1982. They have also been updated at GS-14 and GS-15 to reflect the increased amounts payable at these grades beginning December 18, 1982, when the pay cap was raised. On the last line of the table, the overall average PCAP amount of \$8,570 has been added to provide an estimate of the total average pay at each grade. (We do not have PCA by specific grade averages). Data on the outside income of General Schedule physicians is not available; they are not required to report this income.

The private salaries with which GS salaries (not including PCA) compare most favorably are those of medical school faculty when base pay alone is used in the latter, and the surrounding states from the Michigan State Survey (See Table E). GS pay including PCA surpasses that of the Michigan counties and states surrounding Michigan. However, it is less than that for the State of Michigan; private practice physicians; medical school faculty with outside income; the Federal uniformed services with their bonus; and VA pay with bonus.

The intergrade differentials, i.e., the percentage difference in the rates of pay from grade to grade, varied widely from one system to another. The comparisons of ranges below are for the three grades from GS-12 through GS-15 as listed in Table E.

Michigan State	14%
States surrounding Michigan	15%
Michigan counties	18%
Medical School Faculty: Base Pay	90%
Medical School Faculty: Base Pay and Supplemental	84%
Medical School Faculty: Base Pay, Supplemental, outside income	83%
Federal Uniformed Services	59%
Federal VA Physicians	14%
General Schedule	48%
General Schedule (including PCA)	40%

The General Schedule salary range from GS-12 through GS-15 is much greater than VA, Michigan State, or the other state ranges, but its range, at 40-48 percent, is well below most of the ranges reported for faculty.

TABLE E
FEDERAL/NON-FEDERAL PHYSICIAN SALARIES

Source/Date	GS-11	GS-12	GS-13	GS-14	GS-15	Differential GS-12 to GS-15
<u>Michigan State Survey</u>						
1/1/82						
State Employees	N/A	\$67,516 35%*	70,886 26%*	69,638** 10%*	76,939** 11%*	14%
Surrounding States	N/A	44,782 -11%*	46,946 -20%*	49,608 -28%*	51,418 -35%*	15%
Michigan Counties	N/A	48,006 -4%*	49,275 -14%*	56,846 -12%*	N/A	18%
<u>AMA Socioeconomic</u>						
<u>Monitoring System</u>						
6/82	42,882 33%*	54,458 9%*	65,166 16%*	N/A	N/A	--
<u>Medical School Faculty</u>						
1981-1982	N/A	41,700	58,000	69,000	79,300	90%
Base Pay Only		-20%*	3%*	9%*	14%*	
Base Pay and Supplement	N/A	47,500 -5%*	61,400 9%*	74,400 17%*	87,300 25%*	84%
Base Pay, Supplemental and Outside Contracts	N/A	66,300 33%*	80,400 43%*	94,300 49%*	121,600 75%*	83%
<u>Federal</u>						
12/30/82	N/A	53,500	65,300	73,500	85,100	59%
Uniformed Services with bonus		7%*	37%*	16%*	22%*	
VA with bonus plus outside income (average \$1,400)	N/A	74,900 50%*	79,900 42%*	82,100 29%*	85,500 23%*	14%
General Schedule including Special Rates; not PCA	32,229	41,314	47,599	54,876	61,047	46%
GS with PCA included (average \$8,570); not outside income	40,799	49,884	56,169	63,446	69,617	40%

* Percent greater/less than GS pay, including PCA.

** Psychiatrists only.

Note: Where N/A appears, no grade equivalent could be determined.

Table F from the VA study is included to show average physician pay by employer and by some specialty categories. The data showing pay by employer have been updated by VA to include the December 18, 1982, changes. Three important factors should be noted: (1) VA physician pay includes a figure for outside remuneration averaging \$1,400, and the General Schedule pay and the Uniformed Services pay do not; (2) the figures for office-based physicians are net after expenses but before taxes; and; (3) all the figures reflect the pay of all physicians included in the surveys, not only those coinciding with GS grade levels. Their information shows GS pay is higher than that reported for the Public Health Service, but lower than all other Federal and private pay.

The AMA report on income by specialty states the data are based on a survey which included interviews with 1,215 physicians from a sample considered representative of all U.S. non-Federal patient physicians; it excludes residents. The survey received a 63 percent response rate. The 12 month period covered was from October 1981 through September 1982. It is important to note that factors (2) and (3) in the preceding paragraph apply to this information also. GS pay, as expected, is well behind all the AMA categories. Of course, that General Schedule pay does not include income from practice outside Federal employment.

TABLE F
AVERAGE PHYSICIAN PAY BY EMPLOYER/SPECIALITY

Federal*

Veterans Administration	\$77,200
Uniformed Services	74,500
General Schedule	56,300
Public Health Service	54,900

Private*

Offices	107,100
Medical Schools	85,900
Hospitals	85,200
Health Maintenance Organization	78,500

Specialty**

All Specialties	102,400
General & Family Practice	79,000
Medical Specialties	91,000
Surgical Specialties	129,200
Other Specialties	100,300

* Source: VA Report.

** Source: American Medical Association Socioeconomic Monitoring System Report.

V. CONCLUSIONS

The PCAP is many faceted; a variety of factors, such as, medical categories, grades, agency usage, pay (both for other Federal groups and the non-Federal sector), as well as non-pay factors affecting staffing, preclude arriving at simple conclusions. Instead, we are dealing with a number of inter-related program factors.

PCAP may be covering more categories of medical work than is necessary. Overall statistics show less serious problems for Category III (Physical Fitness), where physicians supply patient services dealing with employee health, e.g., physical examinations and first aid. It is difficult to ascertain why this category presents fewer staffing problems than the others. Disability evaluators (Category IV) who appear to need similar skills and experience are not usually given PCA's because there apparently is no shortage of candidates. Yet, the latter physicians cannot be identified as a non-problem group because they are lumped together with administrators, trainers, and autopsy physicians in Category IV, the "catch-all" category. Thus, while PCAP may be covering categories of physicians which really do not need allowances, it would be difficult to legislatively address the varying degrees of need. More specific data would need to be gathered and, of course, the relative need for PCAP among the categories and levels of physicians would fluctuate.

It is difficult to determine the degree to which monetary allowances solve staffing problems in the field of medicine. Government work covers a wide range of job appeal. It ranges from the poorly-located and, low-graded position in, for instance, a remote Indian or prison location to the prestigious, high-impact and career-enhancing work of an NIH post. At first glance it might appear that larger, more frequent allowances would be needed for the former group. Actually, since NIH candidates can command significantly higher earnings elsewhere and will typically forfeit only so much in earnings for the advantages of their research positions, PCA's are more frequently used for them.

To the extent that General Schedule physicians are underpaid vis-a-vis their VA, Armed Services, and private sector counterparts, PCA's are necessary for sheer survival. The Government's largest employer of physicians, HHS, recommends that the maximum allowance be increased from \$10,000 to \$20,000. They also recommend permanent PCAP legislation and exclusion of PCA from SES aggregate limits. It is true that staffing improvement which peaked in 1980 has begun to erode and GS pay continues to lag behind almost all competitors, so that increased allowances may need to be considered in the future. At this time, however, program experience appears to show a continued need for the current PCA allowances for some types and grade levels of General Schedule physicians.